LEA:_____

Rehabilitation Services
Order for Therapy Evaluation

Student Name: _____ DOB:_____

School: _____ Medicaid#:_____

Referring Therapist: _____ Title: _____

Therapy: ____ P.T. ___ O.T. ___ Speech Therapist=s Phone #:_____

The above named student is in need of an assessment/evaluation.

___ Student is being reviewed for special education placement and an assessment is necessary to determine if services are needed.

___ Student has been undergoing therapy and a significant change in condition/status affecting function has invalidated the most recent evaluation. A new assessment/evaluation is necessary.

Comments:

I authorize an assessment/evaluation as being medically necessary for the above named student.

_____ _____

Signature of Therapist/Title Date